Statewide Epidemiology Workgroup
MINUTES

DATE:	**February 14, 2019**
TIME:	**9 a.m.**
	Meeting
LOCATION:	**Division of Public and Behavioral Health** **4126 Technology Way** **2nd Floor Conference Room** **Carson City, NV 89706**
TELECONFERENCE ONLY:	**(888) 363-4734 / Access Code: 3865799 #**

BOARD MEMBERS PRESENT
James Kuzhippala, Chair Truckee Meadows Community College (TMCC)
Ihsan Azzam, Division of Public and Behavioral Health (DPBH)
Eric Ohlson, Washoe County School District
Ingrid Mburia, DPBH
Pauline Salla, 6th Judicial District/Frontier Community Coalition
Richard Egan, Office of Suicide Prevention
Stephanie Asteriadis Pyle, CASAT, UNR
Judy Henderson, Nevada Coalition to End Domestic and Sexual Violence, Proxy for Susan Meuschke
Kristen Clements-Nolle, NV Center for Health Stats and Info, UNR, Proxy for Wei Yang
Yenh Long, Board of Pharmacy
Brandon Delise, Southern Nevada Health District (SNHD), Proxy for Ying Zhang
Heather Kerwin, Join Together Northern Nevada, Proxy for Jennifer DeLett-Snyder

BOARD MEMBERS ABSENT
Jim Jobin, Vogue Recovery Center
John Fudenberg, Clark County Coroner
Trey Delap, Group Six Partners
Kathryn Barker, Southern Nevada Health District (SNHD)

STAFF & GUESTS PRESENT
Shannon Jensen, Step2
Kelly Muller, Indian Health Services
Nathan Jersey, Nevada Urban Indians
Meg Matta, SAPTA
Jen Thompson, DHHS, Office of Analytics
Dawn Yohey, DPBH
James Baker, OIT
Stephanie Woodard, Behavioral Health Commissioner
Raul Martinez, SAPTA
Rhonda Buckley, SAPTA
Margaret Kedichian, Silver Summit Health Plan
Brook Adie, SAPTA Bureau Chief

1. Introduction, Announcements, and Roll Call
   Mr. Kuzhippala determines there is a quorum.

2. Public Comment – None.

3. Approval of Minutes from the Oct. 18, 2018 Meeting
   Heather Kerwin, proxy for Jennifer DeLett-Snyder, notes DeLett-Snyder was not noted as present/absent for the meeting. No other comments from previous agenda; motions for approval of minutes. Mr. Azzam motions for approval; seconded by Yehn Long. Pauline Salla and Kristen Clements-Nolle both abstained. Motion passes.

4. Update on Web Infrastructure for Treatment Services (WITS)
   (James Baker) – From a prevention coalition side of the project, we just completed the final co-table reviews the first of February. We have four pilots identified, BCC of Carson City, JTNN, CARE and NYE. They will join us for three sessions scheduled, future state work flows that the new system will validate their needs. We will go through test scripts and user acceptance testing to validate the system is working correctly. Out of that we will come up with a tentative go-live date. Right now, it is slated for late March or early April. Once we identify that date, our vendor, FEI, will come on-site and we will have a combined training/implementation. This means the coalitions will bring one or two of their sub-recipients with them, we'll go through full-blown training – superuser kind of training – then we'll actually start to enter the scopes of work into a live system. The plan is to retroactively enter the Block Grant data, so that SAPTA gets some reporting needs out of it for the end of the year. Then we will start working on the SAP funds and the PFS and the other funds as well. When that session is completed, they will go back to their offices and start to do all other funding that they need to do for the year. Some of this will determine that they're not going to do it because there will be no reporting benefits of it, but they'll be trained and ready to put in new funding sources for the next fiscal year. Once we have those four pilots up and running, we've resolved all the go-live issues, we'll look at the other prevention coalitions and get them scheduled and we'll go through the same process with them. For the treatment providers, there's two pieces to this. One is the CDR – the Clinical Data Repository, this is where they're submitting the TEDS data. We've got two pilots identified for that; one is WestCare, the other is Bristlecone. We're actually in the midst of that testing right now. We're expecting one to two weeks of functional testing, where we work out the bugs and the required fields are populating correctly, we're not missing data, the coded tables are coded correctly, etcetera. We'll go through about two to three weeks of data validation, this is where those pilots will submit a full month's worth of data. They'll go through the mapping data and should pass this because the functional testing was successful. And then SNEHA, who is our data analyst, will actually run this data through a live environment with SAMSA, as you would have before the project kicked off. If that data looks good, we then go back to the provider and say submit this again, but now it goes into our live system. At that point, this becomes a monthly test for those two pilots. Once that is successful, we will go back to the other awards providers, there's nine of them, there's at least ten of them, in groups of two or three, in March, April and May, and they'll go through that same process. They'll test, go through data validation, the 30-day submittal process, and then they'll become live and start doing this on a monthly basis as well. The CDR process will only be valid for those who do not join the WITS system. WestCare, we don't believe will join into the WITS system, because they have their own DHR. Some other ones, Bristlecone, Freedom House and some others will be going to the WITS system. They'll go straight into the EHR system. We have five pilots scheduled for that: Bristlecone, Ridge House, Freedom House, UCF and Help of Southern Nevada. They're going to

come on-site with our vendor March 6-7, for a full, on-site demo. GAP analysis will see what work flows might be missing, make sure all data requirements are met, and then we'll actually get started on the project for that.

Stephanie Woodard has questions: Is the WITS system, as an EHR, is it ONC certified?

Mr. Baker – ONC Certified? I do not know.

Ms. Woodard – Something to make this group aware of, I had a discussion with Val last week, because we're going for an 1115 Demonstration Waiver through CMS, and there have been opportunities that the State can now apply for to get some 9010 funding, as well as some other HIT funding for Substance Abuse Treatment Providers, to help them onboard to an EHR treatment to scale. And possibly joining the HIE or other information transfer, they are going to be adding our providers into their HIT roadmap and work with us. My concern is, if the WITS system is not ONC-Certified, then those providers would not necessarily be included in some of the opportunities going forward. If it doesn't have inoperability or connectivity to the HIE, it may end up hindering them in the future from being able to push and pull data through Health Information Exchange, which is ultimately where we want our providers to be able to go.

Mr. Baker – What does ONC stand for?

Ms. Woodard – I don't know, off the top of my head, but is the gold standard for EHRs. This is a new evolution.

Mr. Baker – And this is related to the HIE interoperative ability?

Ms. Woodard – It is. And our HIT at plan for the state. I want to make sure we're taking all of this into consideration before we actively onboard, especially some of our larger, substance abuse treatment providers, onto WITS, if ultimately, it's not going help us to get closer to our goal.

Mr. Kuzhippala asks if there are any other questions. (None)

5. Update on Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey System (Wei Yang)

Kristen Clements-Nolle, (Proxy) – I'll start with YRBS, James asked me to talk about the new items that were added to YRBS. For the 2019 Survey, which is currently in the field, we have 38 substance abuse items – which are around use and availability. The perceived ability is a new area, so we have perceived ability of cigarettes, marijuana, alcohol and prescription drug use. Five of those 38 questions are related to marijuana use, so, because of the new legality, we will be looking at trends, over time. We have a project where we will be comparing rates over time with New Mexico as a comparison state, as they do not have recreational marijuana legalized. We have also added perceived risk and parent disapproval and peer disapproval questions, which are required by a lot of the coalitions who are going for different types of SAMSA funding. Now we should be in full compliance with the use and perceived risk and disapproval questions. We have added six new resiliency questions. We're hoping to look at whether some of these areas of school connectedness, parent-child communication, those types of things can reduce the risk. Items we added previously, still remain, it was a big revision. We had to cut some items, but we worked with the Steering Committee to do that and I think it's a good survey. Our intent is not to change the survey much going forward, it will have a very large substance abuse monitoring component. We've decreased a couple of the nutrition questions and questions that weren't really being used by providers. The Middle School Survey we added back the past 30-day prescription drug use question. That was a question the CDC recommended cutting, and in fact, this Middle School Questionnaire is so close to our High School Questionnaire with substance abuse and mental health, we changed the time periods for the mental health recall. The Middle School Survey is quite shorter than the High School Survey. There will be a lot of changes with the Middle School Survey, retaining the required number of items for CDC, we won't be part of the National Data. I don't think it matters as very few states doing a Middle School Survey and our changes to our Middle School Survey suits our needs for the state much more. We're in the field right now, hoping for the best. The schools are surveyed, surveyed, surveyed. It gets harder every year. We do this

survey and we may be reaching out to some of the coalitions while we collect data in Clark County and Washoe County and about four rural counties. Any questions about YRBS?

Mr. Kuzhippala – Are the perceived questions, are they also at the US level, or specific to Nevada?

Ms. Clements-Nolle – Specific to Nevada.

Mr. Kuzhippala – Are there any changes for active and passive consent permissions?

Ms. Clements-Nolle – No.

Mr. Azzam – Can you give an example of perceived availability.

Ms. Clements-Nolle – Perceived availability is for cigarettes, e-vapor products, alcohol, marijuana and prescription drugs.

Mr. Azzam – Yes. I am not sure what is the difference between perceived availability and resilience.

Ms. Clements-Nolle – Perceived availability is how easy it is to get cigarettes if you wanted some; difficult, fairly difficult, etc. Resiliency questions were adapted from other polls. Example: how often do you talk with your parents about your problems; how often to you talk to your parents about what's right and wrong; how often do you talk to your parents about personal matters. Those questions make up the scale about parent/child communication. These are the two areas in our other research, that have been the strongest predictive factors.

Mr. Azzam – Another question, do these include anything about vaping?

Ms. Clements-Nolle – Yes. We added all the previous questions about vaping, and the ways people use marijuana. I will send James the 2019 Survey.

Mr. Azzam – I am concerned that a kid in middle school with get the survey, and then get it in high school, and may become negatively impacted.

Ms. Clements-Nolle – Even in rural counties, we randomly sample classrooms. The chance of being selected for both, are very low. It is a concern, but we will never know that. Most kids sampled, usually do participate. I would want them to be selected again; but I think that would be very rare, based on the probability, and extremely rare in the larger counties.

Heather Kerwin – I have a question relating to data and trends. Would it be inappropriate to compare the YRBS perception and perceived risk, and parental disapproval data, to the historic questions that would have come out of the school climate survey? Because of methodology used.

Ms. Clements-Nolle – Yes, I believe so. The climate surveys we have now are probably going to stop. Questions in the past in Washoe County, all the questions that were imbedded, identical to the YRBS, were underreported by a great deal in the climate survey compared to the YRBS. I believe that, because it's conducted by the school district, it's electronic, and the teachers are there. It's tied to the student ID, so it's not truly anonymous. So, for that reason, you really can't compare.

Ms. Kerwin – Thank you.

Mr. Kuzhippala – Any other questions? (None)

Ms. Clements-Nolle – I have a quick update from Dr. Yang. In 2018, they had five substance use questions. They included the Ace Module and had two questions on gambling. The data is being compiled and will be ready soon. For the 2019 Survey, the current plan is only for the five substance use questions to be included. The gambling questions are not included. So, if there's a need to include that information, it's getting very close to closing that survey, but wanted the group to be aware those questions are not on the survey.

Mr. Kuzhippala – Is there a reason why they were removed?

Ms. Clements-Nolle – I don't know. There may not be funding for them.

Mr. Kuzhippala – Any other questions? (None) Thank you. Once we get that report we'll send it out to the rest of the SEW. If you're not on the ListServe now, let us know and we can have you added. Email James Kuzhippala, jkuzhippala@tmcc.edu; or Raul Martinez, rmartinez@health.nv.gov.

6. Presentation from Maternal Child Health on Highlights Related to Substance Abuse Issues (Jie Zhang)

Good morning, this is Jen Thompson (Proxy) – Looking at 2018 births, there were 34,803 live births in Nevada. Of those births, we pulled out 1,645 reported tobacco use; 151 reported using alcohol; and 5,622 women reported drug use. Drug use is defined as prescription drugs, over the counter, and illicit drugs. When we broke out the illicit drugs, there was 887 reported illicit drug use. We found age is statistically significant (when looking at drug use). Women under the age of 19 are more likely to use illicit drugs, than the 20-34-year-old age group. Another thing we found interesting, is with education, also decreases use. The lower the education the more use of substances. Race/Ethnicity is not significant; except for in the black and Native American populations. Ingrid mentioned you wanted a report, so, what is it you would like in the report?

Mr. Kuzhippala – I think this was an agenda item on-going for the past few meetings. We wanted to get some general information on with that specific population mainly because when we develop our poll for the upcoming year if there's anything we really want to highlight.

Ms. Woodard - Are there other data points you are willing to hear and consider, other than this. Medicaid has been able to pull really good data as of late. It's not the entirety of the population, at least it's a population we have a lot of (about 50 percent). There are a couple of reports provided over the last year or so.

Ms. Mburia – I would like to get together with the epidemiologist, because this is the year that they are compacting the needs assessment just to make sure that the report you will put out will remind me of what we need to report to the NCH Block Grant, as well as the "something" component.

Mr. Azzam – How did you get the information. Did you do a survey?

Ms. Thompson – This is all self-reported on the birth certificate. I do know some facilities will drug test the mother.

Mr. Azzam – One thing, now we started with a number of deliveries, do we know how many of the newborn, have a (neonatal abstinence syndrome)?

Ms. Thompson – It's in a SAPTA yearly report. We don't have 2018 data yet, hospital billing data yet. But the neonatal abstinence syndrome is going up. As of 2017, 293 infants were admitted for neonatal abstinence syndrome. That could be withdrawal from any substance. Fetal alcohol syndrome is a separate code.

Ms. Woodard – You were also able to bump that against the MENAX. The NICUs, with the exception of UMC, actually all report into a database on the frequency of neonatal abstinence syndrome. And they have that data that's trended over time. I believe what was happening over time, is getting that data and bumping up against new claims data and found there wasn't a whole lot of deviation between the two.

Mr. Azzam – Is there any possibility the newborn baby has the neonatal abstinence syndrome and not admitted?

Ms. Thompson – Yes.

Mr. Azzam – And what is that rate? As I have seen data with higher numbers of this neonatal abstinence syndrome. What is the exact number? We want to see if we're improving, deteriorating. As you mentioned, the number is going up, but what is the correct number?

Mr. Kuzhippala – Ingrid, is that an indicator that is currently collected on FRAMS?

Ms. Mburia – No. That data is provided by the NCH Bureau. We could contact the epidemiologist and she would be able to provide that data. The most recent data would be 2017. But we don't collect that in FRAMS.

Mr. Azzam – I'm wondering about congenital syphilis, and HIV and hepatitis. Because we are seeing an increase in congenital syphilis. Not only in Nevada, but nationwide. So, I would like to see if we could capture this data.

Ms. Thompson – We are doing this already.

Mr. Azzam – Yes, but we have thought about chemical agents, but not biological agents.

Ms. Woodard – To add to that, we also are now going to be implementing the Plan of Safe Care, for infants who are born substance exposed. We will have some of that information. It's not a ton of data, but it's some data I think we might be able to find. The federal law has now changed, that, any exposure during pregnancy, whether substance is legal or illegal, we'll have a lot more of that information coming through.

Mr. Kuzhippala – Okay. We're going to go a little out of order; to Agenda Item Number 8.

7. Review Data Profile and Make Recommendations for Updates (Skipped)

8. Review the Mortality Data Related to Overdoses (Jennifer Thompson)

Ms. Thompson - I pulled overdose deaths from 2016, 2017, 2018 – there were 604 in 2016; 657 in 2017; and, 607 in 2018, but 2018 is preliminary so the number is expected to rise. The current rate is about 22 per 100,000 across the board on that. There is a little bit of a rate change for 2018, but again, that's preliminary. Then I dove down a little further, and looked at opioids, about 400 for each year. For 2018, it's down to 307, but again, preliminary. Then I looked at methamphetamines.
Ms. Woodard – One of the reasons I asked her to pull this data, is after seeing medical examiners data from 2017, we're starting to see an increase in the number of opioid overdose deaths, that also included methamphetamine. So, the co-occurrence of heroin and methamphetamine in overdose deaths, is beginning to look like it's a trend. And we're seeing that on the substance abuse treatment admission side as well. We're seeing people admitted to more substance abuse treatment who have methamphetamine and heroin use. The reason this is so important, the route of administration for methamphetamine and heroin rise is through intravenous. The more we have IV drug use, the more propensity we have to also pretty significant risk for HIV and Hep C outbreaks. We all need to be paying attention to this because this is continuing to be a growing trend. The reason I also wanted to look at this data is because the Federal funds we are getting are those specific to opioids, yet methamphetamine continues to rise, and actually is the cause of overdose deaths, more-so than opioids. Looking at the way these two have this relationship to one another, I've been able to now convince our Federal partners that methamphetamine use is a risk factor for opioid overdose, so we can now start to redirect some of our funds to work with individuals who have methamphetamine use. The more we can start tracking these on-going in the relationship between the two and then route of administration access to harm reduction strategies like needle exchanges and the like, I think we can be more equipped from the ground level in communities, to be responsive and hopefully deter some type of HIV, Hep C outbreak.
Mr. Azzam – Jen, you mentioned the rate of maternal overdose. I missed the frequency; do you mention that?
Ms. Thompson – I did not.
Mr. Azzam – Because to me, I think the number should be quite manageable. It should be a small number for maternal mortality dying because of overdose. If it reaches maternal mortality, it's really widespread. Maternal mortality should be the end point, not the beginning point. Then to me, it's like double-failure.
Ms. Woodard – The risk period that is the highest for maternal overdose is 1-year post-partum. While some women will reach and maintain abstinence during pregnancy, oftentimes because of the stressers that are related to post-partum, relapse can tend to occur. Which is one of the reasons why we have to look at sometimes pregnancy as a protective factor, but in the post-partum period goes up exponentially.
Mr. Kuzhippala – Any other questions for Jen? (None)
Ms. Woodard – One point that is important to make is, we had looked at 2016 data related to opioid prescribing by county, so this is that same data.
Ms. Thompson – No. This is overdoses.
Ms. Woodard - One of the things I didn't realize when we were first reporting that, included in that data was also opioid partial agonists that were being prescribed for the treatment of opioid use disorder.

Those two things are slightly confounding. We're talking about prescription drugs for the treatment of pain and everything else, as well as prescription drugs being prescribed for opioid use disorder. What Jen's been able to do is pull those two things apart, no longer counting them in the same bucket. What I would like to see is, that as our opioid-prescribing rates drop, we at least maintain if not increase the number of individuals who have access medications to treatment of opioid use disorder. We haven't seen that, actually when she pulled those two things apart, we've seen a decrease, a slight decrease, but decrease nonetheless, in the number of individuals who are being prescribed medication-assisted treatment.
Mr. Azzam – May I ask, how did you pull them apart?
Ms. Thompson – Every prescription has an NDC number, a product ID (assigned by CDC), so we researched every single one from the CDC report.
Ms. Woodard – One of the things I thought interesting is now you have the ICB10 Code, that's required on all prescriptions for any controlled substance, from AB474. While the vast majority of prescriptions for medication-assisted treatment are for opioid use disorder, we are also seeing the ICB10 code being back pain, nerve pain, and a number of other things which suboxone buprenorphine, is actually effective for pain management, but it's not really indicated as such. So, we're starting to see a trend for people who are starting to use buprenorphine suboxone for actual pain management.
Mr. Azzam – What drives me crazy, is the back pain a disease, or a symptom?
Ms. Woodard – It's a great question. The whole goal of adding the ICB10 Code was to try and to get to – what is the source of the pain. Pain is a symptom, it's not the primary diagnosis. A long-term opioid prescription for back pain is contraindicated. It's not considered the first line of treatment, and yet when you look at all of the controlled substances being prescribed for back pain by and large for less than 30 days, 30-90 days, and 90 days and over, is the primary.
Mr. Azzam – Is there a way to analyze the providers who are prescribing for back pain, to see if the back pain could be fixed surgically or through physical therapy. Again, treating a symptom is double loss. First, the person's pain is not because of the back; could be herniated disc. The second problem is addiction; so, the treatment is wrong, and the diagnosis is incomplete.
Ms. Woodard – That's one of reasons in AB474, if you wanted to prescribe beyond 90 days, you have to have some type of an evidence-based diagnosis you're working from. It can no longer just be, neuropathy; it's, what is the driving cause of the neuropathy.
Ms. Thompson – Another thing we've completed with Tuoro University is finding the specialty and then we separated out by specialty. So, they're doing some analytics right now. Part of the PFS Grant (not SAPTA PFS Grant), is to create a prescriber report card, two actually. We've hit a lot of barriers with it, it keeps getting delayed, but it's on our list to do. With how massive the prescription monitoring drug program data is, to make it useful, we're going to break it out by specialty in the region. I have that, but I don't have it by doctor, yet. If you'd like to see it, I can send that report to you. Our thought is to create an online dashboard and the pharmacy board can use it and pull the name of the prescriber.
Ms. Woodard – This data is very interesting.
Mr. Kuzzhipala – What might benefit the rest of the group is to send it out.
Ms. Thompson – I sent you (Raul Martinez) two pieces of paper, if you could send them out. There are three separate documents, so I will send them together, to you, if you would send them out after I resend them to you.
Raul Martinez – Okay. Perfect, thank you.
Mr. Kuzhippala – Does anyone have any questions regarding opioids, overdoses or mortality?

9. Nominate and Approve a Data Subcommittee

Mr. Kuzhippala - One thing we wanted to address that we've had issues with in the past, was, every year we develop data epi-profile, that's utilized by MPACT and a lot of grants. Jen's team usually makes the document, we spend a whole lot of time reviewing it, revising it, then developing a sub-committee to

review and revise it … we wanted to work backwards this time. We want to create a sub-committee to help Jen and her team develop the report. So, by the next SEW meeting in May, we can then review and approve it. What I want to do is get a few individuals who really want to help Jen's team out. In the past we have probably three or four people on it, which is perfect. We can add more people if you want. They usually meet once a month or so, enough time for her team to pull the data. If there's anyone willing to give up maybe and hour or two a month to help Jen's team, that would be excellent. Do we have any volunteers? Or anyone who would like to be "voluntold?"

Ms. Woodard – I will take his (Mr. Azzam) place.
Richard Egan – Can you clarify what we'll be looking at.
Mr. Kuzhippala – Reviewing previous Epi Profile, identifying any other areas that need to be addressed. So far, we have Jen, Stephanie and Dr. Clements-Knoll, Dr. Yang, is there anyone else?
Mr. Azzam – What about the State Epis?
Mr. Kuzhippala – We'll reach out to Melissa, that's a good idea.
Ms. Mburia – This is Ingrid, I'd like to volunteer.
Mr. Kuzhippala – This is the largest group we've ever had.
Ms. Woodard – I'm wondering if Ruth would be a good person. You can add Ruth Condray. Brook are you on the call?
Ms. Adie – Yes, I'm on the call.
Ms. Woodard – Are you okay with Ruth joining this group to review the Epi profiles?
Ms. Adie – Yes, absolutely. Unless you want Darcy to do it.
Ms. Woodard – No, I think Ruth would be good.
Mr. Kuzhippala – Okay, so the current list I've got is; Jen Thompson, Dr. Woodard, Melissa our State Epi, Ingrid, Ruth Condray, Dr. Yang or Dr. Clements-Knoll, and Richard Egan. Can I get a motion to approve a data sub-committee to assist with the review and revisions of the coming data Epi Profile?
Mr. Azzam – This I can do.
Mr. Kuzhippala -Thank you, can I get a second?
Ms. Mburia – This is Ingrid, I second.
Mr. Kuzhippala – Thanks, Ingrid. All those in favor? (Unanimous). Opposed (None) Abstain (Dr. Clements-Nolle). Motion passes.

10. Discuss Current Membership and Upcoming Vacancies for Election at the Next Meeting

Mr. Kuzhippala – Every year we do elections. We have rolling positions. We have a Chair, Vice-Chair, and Post-Chair. Every position is a 1-year term. At the end of the next meeting, I will transition to Post-Chair, Kathryn (Barker) will either transition to Chair, and we'll have the position open for Vice-Chair. We always want new faces and individuals to be part of this team because each individua provides a different aspect and goals. We don't have to have individuals nominated today, but if you have anyone who's interested, definitely shoot an email to Kathryn or myself, Raul or Stephen Wood, prior to the upcoming meeting and we can have that put on the agenda. It's a wonderful position, not that much of a burden. It's only four to five meetings a year, and you get to meet a lot of people. Does anyone have any questions regarding that?
Ms. Clements-Nolle – I have a question. It's been a number of years since I've been involved. But in the past, SAMSA's had a membership-required types of people. Do you still have that?
Mr. Kuzhippala – We don't have a required type.
Ms. Clements-Nolle – Not organizations per se, but stakeholders. Like, we need this many people from this organization, and so many from that organization.
Raul Martinez – Our bylaws are not specific in that sense.
Ms. Clements-Nolle – And they're not on the PFS Grant anymore?
Raul Martinez - The membership is based on the requirement in the bylaws.
Ms. Clements-Nolle – Okay.
Mr. Kuzhippala – Currently the requirement is nine members. Is that right?

Raul Martinez – The minimum is eight.
Mr. Kuzhippala – And we've always had more than that, and sometimes that's been issues in the past. We're currently reviewing our current membership over the past year and we've had two individuals who haven't been in attendance. We don't need a motion to remove them, they'll just automatically be dropped off at the end of this meeting. Jim Jobin and John Fudenberg, from Vogue Recovery and Clark County Coroner, will be removed. We're reaching out to their offices to see if there's someone we can get as a replacement for them just because they are great members, and having that specific organization being a part of the SEW gives a dimension to it. If there's anyone else you want involved, definitely reach out to us.
Mr. Azzam – Involving the State Epi is really important.
Ms. Woodard – I find that's a significant missing link. We get great data, but it's the interpretation of the data and looking at the research to figure out what are some of the choice interventions we need to be putting into place, I think can the improve the work of this group evolve to the work of the MPAC is supposed to do, so we are much more targeted. One of the concerns that continues to come up is, the way we use Epi profiles is somehow disconnected from the way we're funding strategies and interventions at the local level. We're tending to just fund everyone for whatever they're choosing to do, versus driving it with all the data we're able to provide to them. We need to change the way we're doing things because SAMSA is not happy. There's such a disconnect that when you look at the Epi profile, then look at the activities that our coalitions are doing and what we're funding them to do, there's not a match.
Mr. Kuzhippala – So, those coalition reports, do they match the Epi profile?
Ms. Thompson – Not coalition reports; we did regional reports. Because of the Behavioral Health Board regions.
Mr. Kuzhippala -So based off the few that we get, during the data sub-committee meetings, we don't advise Epi profiles, or the regional reports would reflect on exactly what they need.
Ms. Woodard – The regional reports are fine. Many of our coalitions cover regions, they don't necessarily cover counties. Those that do cover counties are the larger ones where you have the region is the county. I think those are fine. I want to make sure we're drawing a connection between what the data is telling us and especially the YRBS data, how we're making that connection then to what we're listing as priorities by county as we need these things addressed by our coalitions, so that when they apply for the funding, what the activities are they're applying to do, is directly align with what the data is telling us need to be identified and addressed.
Mr. Azzam – How many coalitions do we have?
Ms. Woodard – Eleven.
Mr. Azzam – I don't remember seeing them attend this meeting.
Ms. Woodard – I don't see why they wouldn't be here. The work of this group actually is what should be driving what it is they're doing on the ground level with the coalition work.
Unknown – And we produce a coalition report every year.
Mr. Kuzhippala – And if there's ever any data they need, Brook, they can always reach out to your team, right?
Mr. Azzam – This is really a very important meeting, very informative. I would really encourage them to attend, each one of the coalitions.
Mr. Kuzhippala – We can reach out to the individual coalitions and see if they want to be part of the meeting.
Ms. Woodard – At the very least, Linda Lang. To say, we need at least some representation. Absent the coalitions, who are on the ground doing the work, I feel like we're working in a vacuum.
Mr. Ramirez – Linda normally does attend the SEW meetings. She was planning to call in, but I don't think she was able to make it.
Mr. Azzam – I don't want to make it a mega meeting, but if would be a good idea if each one of the coalitions would give us an update on what they're doing and where are they in their activities. Eventually, it may be too late.
Ms. Woodard – I think we're working to align. SEW is gathering and analyzing the data and making recommendations. What would be helpful is if they could do it by county or region, to say, these are the

priorities based on what we are seeing in the data. That goes to MPAC, then aligns with us, identifies strategies for activities that could be used by coalitions and other community partners to address some of these issues. That is how we develop our funding. For example, if you are in Mineral County and you have high youth marijuana use, low-perceived risk and high-perceived availability, we know we're going to want you to be working on marijuana with your youth. Which might look different than a neighboring county.
Mr. Kuzhippala – So, we'll reach out to Melissa and Linda Lang, and the coalitions to see if they want to be involved.

11. Make Recommendations for the 2019 Meeting Schedule

Mr. Kuzhippala - For this one, it might be easier, just because we have quite a few proxies this meeting, to send out a Doodle Poll. It won't have specific dates, but we'll have one with general dates, like the first week, or second week, with specific time periods. That might be easier than just having a vote over the phone right now. I can work with Raul and Stephen to get that done.
Mr. Ramirez – What I'm going to shoot for is to have the next three meetings in May, August and November; three or four options of reoccurring meetings.
Mr. Kuzhippala - Maybe we can work with Jen to figure out a timeline, so we can get the report finalized by the upcoming SEW meetings, so when the next MPAC occurs, we don't have to meet multiple times by then.

12. Discuss and Recommend Agenda Items for the Next Meeting

Mr. Kuzhippala – Ideally, we'll have the finalized document or draft version of the Epi profile for the next meeting. We want to keep it relatively short. An update to WITS, review and approve all the data of Epi profile, elections for the Chair and Vice-Chair, as well as the voting in of any additional SEW members who may be interested. Does anyone else have items they want to include in the next SEW?
Ms. Thompson – There's no way I am going to finalize anything by May.
Mr. Kuzhippala – So, it's probably going to be May or June. Depending on when MPAC meets.
Mr. Martinez – If it isn't ready for June, would we be able to push it out for the following meeting in August? Or would we need to have an impromptu meeting before August?
Ms. Woodard – We do. We're trying to align all of this so, that when our federal funds come out in October, we already know what our priorities are. We can start our RFA process, so we can identify, hopefully, know who is getting funded for what and how much, by the time October rolls around. Right now, we're running three to six-months behind the funding cycle. We want to try to get in cadence as much as possible.
Mr. Ramirez – So should we work with Jen as to the soonest we could schedule the first meeting to approve that draft, then I'll send out reoccurring dates for the last two meetings.
Mr. Kuzhippala – We'll work with Jen, we'll work with MPAC to see when that meeting is going to be scheduled.
Mr. Ramirez – For the MPAC meeting, we're looking at scheduling it sometime between March 18 and April 5. I'm going to send out a Doodle Poll by the end of this week proposing dates in those three weeks. That gives them four weeks to figure out their schedule and see which one works best.
Mr. Kuzhippala – So if we get the profile to them in June to July, for the next quarterly meeting, that would be fine?
Ms. Thompson – We'll work on it, yes.
Mr. Kuzhippala – Are there any other items you want discussed at the next meeting? (None)

13. Public Comment

Mr. Kuzhippala – Does anyone have any last words? (None)

14. Adjourn

Mr. Kuzhippala – Thank you everyone for coming, if you have any questions let me know.